

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07995

8018

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rural</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Albert Irwin Anderson</u>		4. DATE OF DEATH <u>July 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26 1877</u>
9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas & Elec</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Anderson</u>	
14. MOTHER'S MAIDEN NAME <u>Annie J. Irwin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-07-2286</u>		17. INFORMANT <u>Mrs. Albert J. Anderson</u> Address <u>Fallston Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic & V disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-14-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 16</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Giovans Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>York Rd Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer-Benson M.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Archer</u>

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
HEALTH DEPT.

2019

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07998

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1 230 Lincoln St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Hayes</u> Last <u>Bayless</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-70</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.P. Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bayless</u>		14. MOTHER'S MAIDEN NAME <u>Emma Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Lillie Pypple - daughter</u>		Address <u>230 Lincoln St. Hlg.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/17/58</u> , 19 <u>58</u> , to <u>July 15, 1958</u> , that I last saw the deceased alive on <u>7/15/58</u> , 19 <u>58</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank W. Wademan</u> M.D.		ADDRESS (Street, city or town, state) <u>407 S. Union Ave Harford</u>	
DATE SIGNED <u>7/14/58</u>			
PHYSICIAN'S NAME (Type) <u>Frank W. Wademan</u>			
22a. BURNAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. ...</u>		24a. REC'D BY REGISTRAR <u>JUL 25 58</u>	
ADDRESS <u>Harford</u>		24b. REGISTRAR'S SIGNATURE <u>W. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7998

CERTIFICATE OF DEATH

Reg. Dist. No.

07997

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u>		d. STREET ADDRESS <u>109 So. Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Bechtold</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/74</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>August Bechtold</u>		14. MOTHER'S MAIDEN NAME <u>Louise Walthers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mr C. Bechtold</u>		Address <u>109 S. Washington, City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis, hypostatic</u> <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19th, 1958</u> to <u>July 4th, 1958</u> that I last saw the deceased alive on <u>July 4th, 1958</u> and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Leo</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Havre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Leo, M.D.</u>		DATE SIGNED <u>July 4th, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 7, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL Cm.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. MADISON MITCHELL</u>		ADDRESS <u>HAVRE DE GRACE</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7999 CERTIFICATE OF DEATH

07998

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.D. #1 Box 144</i>		d. STREET ADDRESS <i>R.F.D. #1 Box 144</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Hugh</i> Middle <i>L.</i> Last <i>Bransford, Jr.</i>		4. DATE OF DEATH Month <i>7</i> Day <i>8</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-29-1875</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	
11. BIRTHPLACE (State or foreign country) <i>Springfield, Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Samuel Bransford</i>		14. MOTHER'S MAIDEN NAME <i>Harriett C. Leatham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>216-12-5436</i>	
17. INFORMANT <i>Mr. Hugh L. Bransford, Jr. Harre de Grace</i>		Address <i>R.F.D. #1, Box 144</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO <i>Chronic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of</i> DUE TO <i>Prostate</i> (c) <i>Prostate</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-8</i> , 19 <i>58</i> , to <i>7-8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7-8</i> , 19 <i>58</i> , and that death occurred at <i>11:45</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. L. Lewis MD</i>		ADDRESS (Street, city or town, state) <i>Harre de Grace, Md.</i>	
DATE SIGNED <i>7/9/58</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-11-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenspring Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Level, Harford Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Celia J. Bullock-Harre de Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>Jul 14 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>W. Deane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07999

8019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON	
c. LENGTH OF STAY IN 1b 43 YRS.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EDWARD BROWN		4. DATE OF DEATH Month Day Year JULY 9, 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1915
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY HYDRO-ELECTRIC	
11. BIRTHPLACE (State or foreign country) DARLINGTON, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILIP L.C. BROWN		14. MOTHER'S MAIDEN NAME MARY BURKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 165-03-0870	
17. INFORMANT MRS. ISABEL R. BROWN, DARLINGTON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 hours MD.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1949 , to July 8, 1958 , that I lost saw the deceased olive on July 8, 1958 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darlington, Md. DATE SIGNED 7/9/58			
ACTUAL SIGNATURE Dudley Phillips MD		PHYSICIAN'S NAME (Type) Darlington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-12-58	
22c. NAME OF CEMETERY OR CREMATORY DARLINGTON		22d. LOCATION (City, town, or county) (State) DARLINGTON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harding, Delta, Pa.		ADDRESS Delta, Pa.	
24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE Alfred	

CERTIFICATE OF DEATH

1. Name of deceased: JOHN J. HARRIS

2. Sex: Male

3. Age: 42

4. Date of birth: 1912

5. Date of death: 1954

6. Place of death: Home

7. Cause of death: Heart Disease

8. Signature of physician: [Signature]

9. Signature of registrar: [Signature]

10. Date of registration: 1954

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1938, AS AMENDED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8000 CERTIFICATE OF DEATH

08000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>41 yrs</u>		d. STREET ADDRESS <u>625 D. Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edward Budnick</u>		4. DATE OF DEATH <u>7/26/58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Alfred Bros Under Penn. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert Budnick</u>		14. MOTHER'S MAIDEN NAME <u>Florentina Hattay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Fordman Lavin</u>		Address <u>625 D. Wash. Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-25</u> , 19 <u>58</u> , to <u>7-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>58</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Simon</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Harford, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harford</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

2000

DATE OF DEATH

PLACE

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS MEDICATION

PREVIOUS TREATMENT

PREVIOUS DIAGNOSIS

PREVIOUS HISTORY

PREVIOUS PHYSICAL

PREVIOUS MENTAL

PREVIOUS SOCIAL

PREVIOUS ECONOMIC

PREVIOUS ENVIRONMENTAL

PREVIOUS GENETIC

PREVIOUS IMMUNE

PREVIOUS INFECTIOUS

PREVIOUS NEUROLOGICAL

PREVIOUS PSYCHIATRIC

PREVIOUS ONCOLOGICAL

PREVIOUS CARDIOVASCULAR

PREVIOUS RESPIRATORY

PREVIOUS GASTROINTESTINAL

PREVIOUS UROLOGICAL

PREVIOUS OBSTETRIC

PREVIOUS GYNECOLOGICAL

PREVIOUS ENDOCRINE

PREVIOUS HEMATOLOGICAL

PREVIOUS IMMUNOLOGICAL

8001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG231 7-11-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEI AIR</u>		c. LENGTH OF STAY IN 1b <u>40 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEI AIR</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hickory Ave and East Broadway</u>				d. STREET ADDRESS <u>Hickory Ave and East Broadway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J. MOSENA</u> Middle <u>WARREN</u> Last <u>BURKINS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u> <u>July 16, 1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS K. WARREN</u>				14. MOTHER'S MAIDEN NAME <u>Mary Noble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>2305 Woods Road</u> <u>Mrs. J. Thomas WARREN WILMINGTON 2, Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ACUTE AND CHRONIC ALCOHOLISM</u> DUE TO <u>OVER</u> (c) <u>SYR</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEI AIR Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>BEI AIR, Harford Co, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster</u>				ADDRESS <u>Broadway and Williams St</u> <u>BEI AIR, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert Couch</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
c. LENGTH OF STAY IN 1b 90 YRS.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARIAN FLORENCE BURKINS		4. DATE OF DEATH Month Day Year JULY 15, 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1868
9. AGE (In years birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) STREET, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ALLEN		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address MRS. JOHN TRIPLETT, STREET, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 JULY, 1958 to 15 JULY, 1958 , that I last saw the deceased alive on 15 JULY, 1958 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin W. Whiteford M.D.		ADDRESS (Street, city or town, state) Street, Harford Co. DATE SIGNED 7/16/58	
PHYSICIAN'S NAME (Type) EDWIN W. WHITEFORD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-18-58	22c. NAME OF CEMETERY OR CREMATORY EMORY	22d. LOCATION (City, town, or county) (State) STREET, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DATE JUL 18 '58	24b. REGISTRAR'S SIGNATURE Alfred Leach

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File last 90

NAME OF DECEASED HARRIS, J. W.

RESIDENCE 1212 N. STREET

DATE OF DEATH June 12, 1905

PLACE OF DEATH Home

AGE 21 YEARS

SEX Male

CAUSE OF DEATH Myocardial Infarction

DIAGNOSIS Myocardial Infarction

Signature

Physician

Signature

DATE OF INTERVIEW June 12, 1905

INTERVIEWER John H. Smith

Signature

Signature

DATE OF DEATH June 12, 1905

INTERVIEWER John H. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8002

CERTIFICATE OF DEATH

08003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SUPERIOR ST.</u>				d. STREET ADDRESS <u>SUPERIOR</u>			
3. NAME OF DECEASED (Type or print) First <u>JEROME</u> Middle <u>CASSADY</u> Last <u>CASSADY</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 11, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED V.A. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>XX KENTUCKY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>WORLDWARI</u>			
17. INFORMANT <u>MRS ESTHER S. CASSADY</u>				Address <u>HAVRE DE GRACE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart disease</u> DUE TO (c) <u>24 hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>417 S. Union Ave Harford</u> DATE SIGNED <u>7/5/58</u> ACTUAL SIGNATURE <u>Dr. R. Madison Mitchell</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. R. Madison Mitchell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>HAVRE DE GRACE, MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JARRETTVILLE	
3. NAME OF DECEASED (Type or print) First Middle Last MARY GERTUDE COE		4. DATE OF DEATH Month Day Year July 21 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 16-1969
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MONROE TRACY		14. MOTHER'S MAIDEN NAME ELLA FLETCHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Miltie C. Biederman		Address Lanham Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 903.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Hip Fracture (c) Open Reduction and Internal Fixation		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while walking	
20c. TIME OF INJURY Month, Day, Year Hour 2 11 1958 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home	20f. (City or town) (County) (State) Bel Air Harford Md.
21. I certify that I attended the deceased from 7/17 , 19 58 , to 7/21 , 19 58 , that I last saw the deceased alive on 7/20 , 19 58 , and that death occurred at 6:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Sadowsky M.D.		A ADDRESS (Street, city or town, state) 1600 S. Union Ave DATE SIGNED 7/21/58	
PHYSICIAN'S NAME (Type) W. H. SADOWSKY		Name of Signer Harford Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-23-58	22c. NAME OF CEMETERY OR CREMATORY Jarrettville	22d. LOCATION (City, town, or county) (State) Jarrettville Md
23. FUNERAL DIRECTOR'S SIGNATURE Marion C. Miltz ADDRESS Jarrettville Md		24a. REC'D BY REGISTRAR DATE JUL 24 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8004

CERTIFICATE OF DEATH

08005

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> 6. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b. <u>4hr 19min + Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. STREET ADDRESS <u>Box 657</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Crawford</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1958</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Donald Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Margaret Koser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>William D. Crawford</u>		Address <u>Joppa, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7620 Ateptan</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7620</u> DUE TO (c) <u>7620</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4hr 19 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7620</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/17, 1958</u> , to <u>7/17, 1958</u> , that I last saw the deceased alive on <u>7/17, 1958</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. V. Hatem</u>		M.D. <u>602 S. 4th Ave.</u>	
PHYSICIAN'S NAME (Type) <u>F. V. Hatem</u>		ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July, 18, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>	22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hatem</u>		24a. REC'D BY REGISTRAR <u>W. J. Hatem</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Hatem</u>
ADDRESS <u>Abingdon, Md.</u>		DATE <u>JUL 22 '58</u>	

2071346XU5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8005

1-1-1911

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "1866"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Maryland"]</p>		<p>6. OCCUPATION [Faint text, possibly "Farmer"]</p>		<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>9. DATE OF DEATH [Faint text, possibly "1911"]</p>		<p>10. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>13. SIGNATURE OF WITNESS [Faint signature]</p>		<p>14. SIGNATURE OF WITNESS [Faint signature]</p>		<p>15. SIGNATURE OF WITNESS [Faint signature]</p>		<p>16. SIGNATURE OF WITNESS [Faint signature]</p>	

17. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the death occurred at the place and on the date stated above.

18. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the death occurred at the place and on the date stated above.

19. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the death occurred at the place and on the date stated above.

20. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the death occurred at the place and on the date stated above.

8005 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>				c. LENGTH OF STAY IN 1b <u>8 hrs 20 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Max</u> Last <u>Elliott</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17-1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country)				13. FATHER'S NAME <u>Robert + James Elliott</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Osborne</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>244-07-2173</u>				17. INFORMANT <u>Martin Elliott Jr (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>58</u> , to <u>July 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>58</u> , and that death occurred at <u>12:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Sandechi M.D.</u>				ADDRESS (Street, city or town, state) <u>Bel Air, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>A. Sandechi</u>				DATE SIGNED <u>7.9.58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bellin Hartford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Bellin M.D.</u>				ADDRESS <u>Bellin</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alberich</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use. The burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8006

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
c. LENGTH OF STAY IN 1b <u>8 YRS</u>		d. STREET ADDRESS <u>1 50 LEE ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>50 LEE ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH HARRIETT FRISTOE</u>		4. DATE OF DEATH Month Day Year <u>JULY 25 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 31, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>THOMAS ALLEN RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROBERT FRISTOE, BEL AIR, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HYPERTENSIVE</u> DUE TO <u>CARDIO-VASCULAR DISEASE IN CONGESTIVE FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>OVER 8 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY, 1954</u> to <u>JULY 25, 1958</u> , that I last saw the deceased alive on <u>JULY 23, 1958</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		<u>307 HICKORY</u> <u>JULY 25, 58</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN</u>		<u>BEL AIR, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>July 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>	
22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Harford Co. Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin H. Kurtz</u>		ADDRESS <u>Jarrettsville, Md</u>	
24a. REC'D BY REGISTRAR <u>JUL 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Grace</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x (Harford) Perryman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D O A Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Aberdeen * 1.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Hugo</u>	First Middle Last <u>Goerges</u>	4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Tool and dye worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt Aircraft</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Hugo Goerges Sr.</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hugo E. Goerges</u>		Address <u>Towson 4, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . (Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>)			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bo Air</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		<u>7-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darring</u>		ADDRESS <u>Aberdeen md.</u>	
24a. REC'D BY REGISTRAR <u>UL 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Aberdeen</u>	

M

99

I

2

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Birth: _____

6. Date of Death: _____

7. Place of Death: _____

8. Cause of Death: _____

9. Manner of Death: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

13. Signature of Physician: _____

14. Signature of Nurse: _____

15. Signature of Family: _____

16. Signature of Other: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

27. Signature of Other: _____

28. Signature of Other: _____

29. Signature of Other: _____

30. Signature of Other: _____

31. Signature of Other: _____

32. Signature of Other: _____

33. Signature of Other: _____

34. Signature of Other: _____

35. Signature of Other: _____

36. Signature of Other: _____

37. Signature of Other: _____

38. Signature of Other: _____

39. Signature of Other: _____

40. Signature of Other: _____

41. Signature of Other: _____

42. Signature of Other: _____

43. Signature of Other: _____

44. Signature of Other: _____

45. Signature of Other: _____

46. Signature of Other: _____

47. Signature of Other: _____

48. Signature of Other: _____

49. Signature of Other: _____

50. Signature of Other: _____

51. Signature of Other: _____

52. Signature of Other: _____

53. Signature of Other: _____

54. Signature of Other: _____

55. Signature of Other: _____

56. Signature of Other: _____

57. Signature of Other: _____

58. Signature of Other: _____

59. Signature of Other: _____

60. Signature of Other: _____

61. Signature of Other: _____

62. Signature of Other: _____

63. Signature of Other: _____

64. Signature of Other: _____

65. Signature of Other: _____

66. Signature of Other: _____

67. Signature of Other: _____

68. Signature of Other: _____

69. Signature of Other: _____

70. Signature of Other: _____

71. Signature of Other: _____

72. Signature of Other: _____

73. Signature of Other: _____

74. Signature of Other: _____

75. Signature of Other: _____

76. Signature of Other: _____

77. Signature of Other: _____

78. Signature of Other: _____

79. Signature of Other: _____

80. Signature of Other: _____

81. Signature of Other: _____

82. Signature of Other: _____

83. Signature of Other: _____

84. Signature of Other: _____

85. Signature of Other: _____

86. Signature of Other: _____

87. Signature of Other: _____

88. Signature of Other: _____

89. Signature of Other: _____

90. Signature of Other: _____

91. Signature of Other: _____

92. Signature of Other: _____

93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08009

8021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air R.D.,		c. LENGTH OF STAY IN 1b 30 yrs.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, R.D.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Emmorton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle Burd Last Grubb				4. DATE OF DEATH Month July Day 4 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1867		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Sopwith				14. MOTHER'S MAIDEN NAME Gertrude Messiter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Violet Mc Lean		Address Bel Air, R.D., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED SENILITY DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. _____ Month, Day, Year _____ 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov , 19 56 , to JULY , 19 58 , that I last saw the deceased alive on 3 JULY , 19 58 , and that death occurred at 4:00 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harvey P. Sidwell				ADDRESS (Street, city or town, state) 401 Franklin St. Bel Air Md.			
DATE SIGNED 4 July 58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Search			

CERTIFICATE OF DEATH

802

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1900		BALTIMORE		NATURAL	
AGE		SEX		RACE	
60		M		W	
BIRTH		MOTHER		FATHER	
JAN 10 1840		JANE		JOHN	
EDUCATION		OCCUPATION		RELIGION	
HIGH SCHOOL		LABORER		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		MEDICAL ATTENDANCE	
NONE		HEART DISEASE		YES	
DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN	
JAN 10 1900		BALTIMORE		J. H. [Signature]	
DATE OF BURIAL		PLACE OF BURIAL		SIGNATURE OF MINISTER	
JAN 10 1900		BALTIMORE		W. H. [Signature]	
DATE OF REGISTRATION		PLACE OF REGISTRATION		SIGNATURE OF REGISTRAR	
JAN 10 1900		BALTIMORE		J. H. [Signature]	

RECEIVED
JAN 10 1900
BALTIMORE

8008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN 1b <u>6HR. 55MIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Larry</u> First <u>Wayne</u> Middle <u>Lee</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1958</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>55</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Arlen R. Hall</u>				14. MOTHER'S MARDEN NAME <u>Vesta Barker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Arlen R. Hall</u>		Address <u>204 Wilson St. Havre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY ATELECTASIS</u> DUE TO (c) <u>PRE NATAL INTRAUTERIN DISTRESS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-29</u> , 19 <u>58</u> , to <u>7-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>58</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Gunther D. Hirsch</u> M.D. <u>421 CONGRESS AVE.</u>							
PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u> <u>HAVRE DE GRACE Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Tarring</u> <u>Tarring Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alberich</u>	

2071223XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8022

CERTIFICATE OF DEATH

08011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle Bertha Last Harris				4. DATE OF DEATH Month July Day 25 Year 1958			
5. SEX female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Harris				14. MOTHER'S MAIDEN NAME Lillie Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Harris Address Abingdon Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) glomerular nephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7-2 , 19 58 , to 7-25 , 19 58 , that I last saw the deceased alive on 7-25 , 19 58 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-25-58							
ACTUAL SIGNATURE Fred O. Hodus M.D.							
PHYSICIAN'S NAME (Type) Fred O. Hodus				Edgewood R.D., Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July, 28, 1958		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McKen				ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE JUL 30 '58	
				24b. REGISTRAR'S SIGNATURE W. J. Leach			

CERTIFICATE OF DEATH

1932

DECEASED NAME JAMES H. HARRIS		SEX Male		AGE 68	
DATE OF DEATH Jan 11, 1932		TIME OF DEATH 11:30 AM		PLACE OF DEATH Home	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan 11, 1864		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF JUDGE (None)	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08012

8023

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Darlington</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Darlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Laura</u> (First) <u>Hart</u> (Middle) (Last)		4. DATE OF DEATH <u>July 1</u> , 19 <u>58</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 9 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homelancing</u>	11. BIRTHPLACE (State or foreign country) <u>M. C. U. S. A.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr</u>	
17. INFORMANT & ADDRESS <u>John Blevins</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Darlington, Md</u>	
442X IMMEDIATE CAUSE (A) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Cardio renal disease</u>		<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 2</u> , 19 <u>55</u> , to <u>July 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Dudley Philip</u>		DATE SIGNED <u>7/3/58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Darlington</u>	
DATE THEREOF <u>July 3 1958</u>		LOCATION (City, town, or county) <u>Harford Co, Md.</u>	
24. REC'D BY REGISTRAR <u>Jul 7 '58</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>	
REGISTRAR'S SIGNATURE <u>W. E. Leaven</u>		ADDRESS <u>Darlington</u>	

CERTIFICATE OF DEATH

1922

Reg. Dist. No. 182

1. NAME OF DECEASED

MARYLAND

DEATH STATE

DEATH DATE

DEATH TIME

DEATH PLACE

DEATH CAUSE

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

DEATH TIME

DEATH PLACE

INVESTIGATOR

REGISTRAR

DATE

8009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	c. LENGTH OF STAY IN 1b <u>30 YRS</u>	24c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>109 N. UNION AVE.</u>	d. STREET ADDRESS <u>109 N. UNION AVE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>CARTY</u> Last <u>JOHNSON</u>	4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1958</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12, 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN E CARTY</u>	14. MOTHER'S MAIDEN NAME <u>SARAH BAKER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>MO. ELIZABETH EVANS</u> Address <u>HAVRE DE GRACE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardiac Transpiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arterio Sclerosis</u> DUE TO <u> </u> (c) <u>Cardio Vascular Disease</u> DUE TO <u> </u>	INTERVAL BETWEEN ONSET AND DEATH <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour a. p. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Jan 16</u> , 19 <u>56</u> , to <u>July 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-5-58</u> , and that death occurred at <u>3:50 P</u> . M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <u>HAVRE DE GRACE, MD.</u>	DATE SIGNED <u>7/9/58</u>				
ACTUAL SIGNATURE <u>P. H. Harris</u>	M.D. <u> </u>					
PHYSICIAN'S NAME (Type) <u>P. H. Harris</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-11-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAKER'S CEM.</u>	22d. LOCATION (City, town, or county) <u>HARFORD Co.</u> (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison McNeil</u> ADDRESS <u>HAVRE DE GRACE MD.</u>	24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8010

Item 9 File # 232 7-30-58 et.

CERTIFICATE OF DEATH

08014
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>about 50 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>559 Girard St.</i>		d. STREET ADDRESS <i>559 Girard St.</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Jessie</i> Middle <i>C.</i> Last <i>Johnson</i>			4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14, 1888</i>		9. AGE (In years last birthday) <i>69 yrs.</i>
		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Schoolteacher</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Harre de Grace, Md.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
---	---	--	---

13. FATHER'S NAME <i>George Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Maria Camphor</i>
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Naomi Camphor</i>
---	--	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterio sclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>May 10</i> , 1958, to <i>July 5</i> , 1958, that I last saw the deceased alive on <i>July 5</i> , 1958, and that death occurred at <i>8:20 A.M.</i> , from the causes and on the date stated above.	
--	--

ACTUAL SIGNATURE <i>George T. Stansbury</i>	M.D. <i>569 Revolution St., Harre de Grace, Md.</i>	DATE SIGNED <i>7/7/58</i>
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-9-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Berkley, Harford Co., Md.</i>
--	--------------------------------------	---	---

23. FUNERAL DIRECTOR'S SIGNATURE <i>Atelia J. Bullock</i>	ADDRESS <i>Harre de Grace, Md.</i>	24a. REC'D BY REGISTRAR <i>Jul 8 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Atelia J. Bullock</i>
--	---------------------------------------	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
RECEIVED
JAN 10 1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1865		Boston, Mass.	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		2 Weeks		10:30 AM	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Carpenter		High School		Married		Roman Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Minister		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8024 CERTIFICATE OF DEATH

08015

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		STATE Md.		COUNTY HARFORD			
CITY (If outside corporate limits, write RURAL OR and give nearest town) RURAL-BEL AIR		LENGTH OF STAY (in this place) 3 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) ABERDEEN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD CONVALESCENT HOME				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) KATHERINE		(Middle) A.		(Last) JOHNSON		(Month) JULY (Day) 11 (Year) 1958	
5. SEX FEM.	6. COLOR OR RACE WH.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 14 1864	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State of foreign country) Rapidan Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Wm. H. Willson				14. MOTHER'S MAIDEN NAME Mary Feather			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unborn		17. INFORMANT & ADDRESS 714 Revolution St. 21- J. R. Johnson Harford Co. Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cardio-vascular-renal disease							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. _____		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 5, 1956 to July , 19 58 , that I last saw the deceased alive on July , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above.							
SIGNATURE Willard P. Hudson				DATE SIGNED 7-25-58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/25/58		NAME OF CEMETERY OR CREMATORY Forest Hill		LOCATION (City, town, or county) Harford, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Willard P. Hudson		25. FUNERAL DIRECTOR'S SIGNATURE Willard P. Hudson		ADDRESS Harford, Md.	
DATE JUL 31 '58							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08016

8025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> c. LENGTH OF STAY IN 1b <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 136</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. Whiteford</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John David Knoop</u> First Middle Last 4. DATE OF DEATH <u>July 16 1958</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Apr. 16, 1948</u> 9. AGE (In years last birthday) <u>10</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL E. KNOOP</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>MARGERETHA GALLION</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>CARL E. KNOOP, WHITEFORD, MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>~</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident - auto pedestrian type</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. <u>7-16</u> 19 <u>58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 136</u> 20f. (City or town) <u>Whiteford</u> (County) <u>Hartford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin, MD.</u> DATE SIGNED <u>7-16-58</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DUBLIN SOUTHERN</u>		22d. LOCATION (City, town, or county) (State) <u>DUBLIN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins, Delta, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE JUL 18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
8002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
WEAVER

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: 10/15/1968

5. Place of Death: Home

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Signature: 10/16/1968

10. Address of Medical Examiner: 123 Main St, Baltimore, MD

11. Telephone Number: 555-1234

12. Signature of Coroner: [Signature]

13. Date of Signature: 10/16/1968

14. Address of Coroner: 456 Elm St, Baltimore, MD

15. Telephone Number: 555-5678

16. Signature of Registrar: [Signature]

17. Date of Signature: 10/16/1968

18. Address of Registrar: 789 Oak St, Baltimore, MD

19. Telephone Number: 555-9012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08017
8011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abie-dee</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abie-dee</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp</u>		d. STREET ADDRESS <u>306 S. Philadelphia Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Kublin</u>		4. DATE OF DEATH <u>July 22 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/27/1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles Kublin</u> Address <u>115 S. Phila. Road Aberdeen Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R femur</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 days</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Lobular pneumonia, bilateral</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of tree</u>	
20c. TIME OF INJURY Month, Day, Year <u>3 7-18 58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerold C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>7-22-58</u>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>		22d. LOCATION (City, town, or county) <u>Harford</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Livingston</u> ADDRESS <u>Harford</u>		24a. REC'D BY REGISTRAR <u>JUL 25 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
MASSACHUSETTS

1

103
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

DATE

TIME

AGE

SEX

PLACE

CITY

COUNTY

STATE

COUNTRY

ZIP

TELEPHONE

EDUCATION

OCCUPATION

RELIGION

POLITICAL PARTY

ETHNICITY

LANGUAGES

DISABILITIES

ALLERGIES

PREVIOUS ILLNESSES

PREVIOUS SURGERIES

PREVIOUS TRAUMAS

PREVIOUS DRUG USE

PREVIOUS ALCOHOL USE

PREVIOUS TOBACCO USE

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8012

CERTIFICATE OF DEATH

08018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STREET <i>Harford Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>722 Erie</i>			
3. NAME OF DECEASED (Type or print) <i>Peter David Langnis</i>				4. DATE OF DEATH <i>7/20/58</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/26/1914</i>	
9. AGE (In years lost birthday) <i>44</i> yrs.		10. UNDER 1 YEAR <i>Months</i>		11. UNDER 24 HRS. <i>Days</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cafe Operator</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>			
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Langnis</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Comitti</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>			
17. INFORMANT <i>Tilly Langnis</i>				Address <i>722 Erie St. Harford</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Coronary arteriosclerosis</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <i>Sudden 1 1/2 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 19th, 1958</i> to <i>July 20th, 1958</i> , that I last saw the deceased alive on <i>July 20th, 1958</i> and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward C. Loo, M.D.</i>				DATE SIGNED <i>July 22nd 1958</i>			
PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>				21b. REGISTRAR'S SIGNATURE <i>Harold Chase, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>7/23/58</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Not Buried</i>				22d. LOCATION (City, town, or county) (State) <i>Harford Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold Chase</i>				24a. REC'D BY REGISTRAR <i>W. Leach</i>			
ADDRESS <i>Harford Md.</i>				24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>			
DATE <i>Jul 25 58</i>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8031

CERTIFICATE OF DEATH

08019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground d. STREET ADDRESS Quarters 116 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle MARGARET Last MALONEY		4. DATE OF DEATH Month July Day 24 Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 17, 1901
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Harry Bloch		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT James Irving Maloney (Husband)		Address Qtrs 116 Aberdeen n Proving Gd Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Collapse DUE TO Metastatic breast carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x (c)		INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 July 1958 , to 24 Jul 1958 , that I last saw the deceased alive on 1425 hrs 24 Jul 58 , and that death occurred at 2:25P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L Corn		DATE SIGNED 24 July 58	
PHYSICIAN'S NAME (Type) ROBERT L CORN CAPT MC		USAH ABERDEEN PG MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/29/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John B. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR JUL 20 1958		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8037

Decedent's Name: [Illegible] Sex: [Illegible] Race: [Illegible] Date of Birth: [Illegible]

Place of Birth: [Illegible] Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Immediate Cause: [Illegible] Underlying Cause: [Illegible]

Date of Death: [Illegible] Time of Death: [Illegible]

**FOR STATE
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **08020**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
c. LENGTH OF STAY IN 1b —		d. STREET ADDRESS 125 N. Cann St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NS Route 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paitzel Meadows		4. DATE OF DEATH July 9 1958	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1931
9. AGE (in years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Airplane	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Meadows		14. MOTHER'S MAIDEN NAME Ina Mc Guire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 234-48-1048	
17. INFORMANT Laura B. Meadows,		Address Edgewood, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto auto type	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-8 7-8 1958	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Harford	20f. (City or town) (County) (State) Toppa Harford MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air	
EXAMINER'S NAME (Type) Gerald C Palmer MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MD	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/10/1958	22c. NAME OF CEMETERY OR CREMATORY ADDRESS Johnson Funeral Home	22d. LOCATION (City, town, or county) (State) Switzer, Logan Co., W. Va.,
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McOmery		24a. REC'D BY REGISTRAR Abingdon, Maryland.	
24b. REGISTRAR'S SIGNATURE W. H. Smith		DATE JUL 14 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

RECEIVED
MAY 10 1961
BALTIMORE

1. NAME OF DECEASED: JOHN J. SMITH

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: MAY 10 1961

5. TIME OF DEATH: 10:30 AM

6. PLACE OF DEATH: HOME

7. CAUSE OF DEATH: HEART DISEASE

8. MANNER OF DEATH: NATURAL

9. SIGNATURE OF EXAMINER: [Signature]

10. SIGNATURE OF WITNESS: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8013

CERTIFICATE OF DEATH

08021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>Ann</u> Last <u>Mink</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19 1957</u>		9. AGE (In years last birthday) yrs. <u>15</u>		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Allen Mink</u>				14. MOTHER'S MAIDEN NAME <u>Naomi T Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robert Mink - father</u> Address <u>Forest Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyopneumothorax</u> DUE TO (c) <u>Staph pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>2 weeks</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cleft palate</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/30</u> , 19 <u>58</u> , to <u>7/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>58</u> , and that death occurred at <u>6:13</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Theodore H. Gaiser</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Hartford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin S. Kutz</u>				ADDRESS <u>Garrettsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u>			

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8027

CERTIFICATE OF DEATH

08022

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eliza Middle Dora Last Morrison				4. DATE OF DEATH Month July , Day 13 , Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1875		9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kyle Hannah				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Archie Morrison, Aberdeen, R.D., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arterial sclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 5 , Month 19 , Day 19 , Year 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 3 , 19 58 , to July 14 , 19 58 , that I last saw the deceased alive on July 13 , 19 58 , and that death occurred at 11 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred O. Hodous M.D.				ADDRESS (Street, city or town, state) Edgewood Md. DATE SIGNED 7-14-58			
PHYSICIAN'S NAME (Type) Fred O. Hodous				Edgewood Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Wallace & Wallace		22d. LOCATION (City, town, or county) (State) Lewisburg, Greenbrier, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart R. McCann				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '58	
				24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		CITY, COUNTY AND STATE	
ST. LOUIS, MISSOURI		ST. LOUIS, MISSOURI	
AGE		SEX	
35		MALE	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MANNER OF DEATH	
ATTORNEY		SUICIDE	
CAUSE OF DEATH		IMMEDIATE CAUSE	
FIREARMS WOUND		FIREARMS WOUND	
MANNER OF DEATH		MANNER OF DEATH	
SUICIDE		SUICIDE	
PLACE OF DEATH		PLACE OF DEATH	
ST. LOUIS, MISSOURI		ST. LOUIS, MISSOURI	
DATE OF DEATH		DATE OF DEATH	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF JURY		SIGNATURE OF JURY	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8028
CERTIFICATE OF DEATH

08023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anita Middle Fay Last Mullins		4. DATE OF DEATH Month July Day 14 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1956
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Mullins		14. MOTHER'S MAIDEN NAME Lena Bowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT David Mullins,		Address Bel Air, R.D., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BRONCHIAL 086X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RUBELLA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X HYDROCEPHALIC		INTERVAL BETWEEN ONSET AND DEATH 24 HRS 4 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 27, 1956 to JULY 14, 1958 , that I last saw the deceased alive on JULY 14, 1958 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip W. Heuman M.D.		DATE SIGNED JULY 14, 1958	
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN		BEL AIR, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon Harford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McLaughlin		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR JUL 17 '58		24b. REGISTRAR'S SIGNATURE Alfred	

8029 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Georgia</u>		COUNTY <u>Peach</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Army Chemical Center</u>		LENGTH OF STAY (in this place) <u>about 12 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Byron</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Quarters 253 Everett Road</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Doris</u>		(Middle) <u>B</u>		(Last) <u>Muth</u>		(Month) (Day) (Year) <u>July 18 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11 Oct. 1908</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>William Benson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Brownsell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Col., Roy W. Muth, Army Chemical Center, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Probable Embolus</u>						<u>Estimated</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart Disease</u>						<u>20 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Post mitral commissurotomy 7 years ago</u>						<u>7 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 July, 1948</u> , to <u>18 July, 1958</u> , that I last saw the deceased alive on <u>17 July, 1958</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Collins Harvey</u>				ADDRESS (Street, city, town, state) <u>Aberdeen Proving Ground, Md.</u>		DATE SIGNED <u>7/18/1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 21, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 22 '58</u>		REGISTRAR'S SIGNATURE <u>Alv. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard W. Brown Jr.</u>		ADDRESS <u>Abingdon, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

See, Page No.

THE DEPARTMENT OF HEALTH OF MARYLAND

NAME OF DECEASED

MARRIAGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

DEPARTMENT OF HEALTH

TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8032

CERTIFICATE OF DEATH

Reg. Dist. No.

08025

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY El Dorado	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Placerville 43X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, APG, Md.		d. STREET ADDRESS 97 Ben Horn Street	
3. NAME OF DECEASED (Type or print) First Perry Middle Jordan Last Prescott		4. DATE OF DEATH Month July Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1938
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME Harold S. Prescott		14. MOTHER'S MAIDEN NAME Marion Estell (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Presently		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Army Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma multiple DUE TO (c) Fracture, compound, left femur and pelvis		INTERVAL BETWEEN ONSET AND DEATH 25 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was hit by train.	
20c. TIME OF INJURY Month, Day, Year Hour 7:05 p. m. July 7 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aberdeen		20f. (City or town) (County) (State) Harford Md	
21. I certify that I attended the deceased from 7 July 19 58 , to _____, 19____, that I last saw the deceased alive on 7 July 19 58 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert L. Corn, Capt. MC M.D.			
PHYSICIAN'S NAME (Type) ROBERT L. CORN, CAPT, MC U.S. Army Hospital, APG, Md. 7 July 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 7-9-58	
22c. NAME OF CEMETERY OR CREMATORY PLACERVILLE		22d. LOCATION (City, town, or county) (State) PLACERVILLE CALIFORNIA	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
24b. REGISTRAR'S SIGNATURE W. L. Smith			

• 50 •

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>H&Sord</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>H&Sord</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Hall S. Preston</u>		4. DATE OF DEATH <u>July 10 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 29 1873</u>
9. AGE (in years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Preston</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>	
17. INFORMANT <u>Wm Russell Preston Fallston, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>7-10-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Gluck Janet Hodges</u>		24a. REC'D BY REGISTRAR <u>JUL 15 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

FOR STATE
HEALTH DEPT

8030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF TEXAS DEPARTMENT OF HEALTH - IN TEXAS

DECEASED
NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
CITY
COUNTY
STATE

1. CAUSE OF DEATH	
2. MANNER OF DEATH	
3. PLACE OF DEATH	
4. TIME OF DEATH	
5. SIGNATURE OF EXAMINER	
6. SIGNATURE OF WITNESSES	
7. SIGNATURE OF CORONER	
8. SIGNATURE OF JURY	
9. SIGNATURE OF JUDGE	
10. SIGNATURE OF CLERK	
11. SIGNATURE OF SHERIFF	
12. SIGNATURE OF DEPUTY SHERIFF	
13. SIGNATURE OF CONSTABLE	
14. SIGNATURE OF DEPUTY CONSTABLE	
15. SIGNATURE OF TOWNSHIP CLERK	
16. SIGNATURE OF COUNTY CLERK	
17. SIGNATURE OF STATE CLERK	
18. SIGNATURE OF ATTORNEY GENERAL	
19. SIGNATURE OF COMMISSIONER OF HEALTH	
20. SIGNATURE OF SECRETARY OF HEALTH	
21. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH	
22. SIGNATURE OF CHIEF OF BUREAU OF VITAL STATISTICS	
23. SIGNATURE OF CHIEF OF BUREAU OF PUBLIC HEALTH	
24. SIGNATURE OF CHIEF OF BUREAU OF LABOR	
25. SIGNATURE OF CHIEF OF BUREAU OF EDUCATION	
26. SIGNATURE OF CHIEF OF BUREAU OF AGRICULTURE	
27. SIGNATURE OF CHIEF OF BUREAU OF COMMERCE	
28. SIGNATURE OF CHIEF OF BUREAU OF MINES	
29. SIGNATURE OF CHIEF OF BUREAU OF FOREST AND RANGELANDS	
30. SIGNATURE OF CHIEF OF BUREAU OF NATURAL RESOURCES	
31. SIGNATURE OF CHIEF OF BUREAU OF PUBLIC UTILITIES	
32. SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION	
33. SIGNATURE OF CHIEF OF BUREAU OF WATER RESOURCES	
34. SIGNATURE OF CHIEF OF BUREAU OF WILDLIFE	
35. SIGNATURE OF CHIEF OF BUREAU OF ZOOLOGICAL RESOURCES	
36. SIGNATURE OF CHIEF OF BUREAU OF BOTANICAL RESOURCES	
37. SIGNATURE OF CHIEF OF BUREAU OF ZOOLOGICAL RESOURCES	
38. SIGNATURE OF CHIEF OF BUREAU OF BOTANICAL RESOURCES	
39. SIGNATURE OF CHIEF OF BUREAU OF ZOOLOGICAL RESOURCES	
40. SIGNATURE OF CHIEF OF BUREAU OF BOTANICAL RESOURCES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08027

8014 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARTFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 hrs 20 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD Memorial Hospital</u>			d. STREET ADDRESS <u>517 S Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Riley</u> Middle <u>Riley</u> Last <u>Riley</u>			4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 16, 1958</u>		9. AGE (If years lost birthday) yrs. <u>5</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Joseph Riley</u>			14. MOTHER'S MAIDEN NAME <u>Milneed Elsie Knight</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pre-hypertensive atherosclerosis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>762.5</u> DUE TO (c) <u>762.5</u> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs 20 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>July 16, 1958</u> to <u>July 16, 1958</u> , that I last saw the deceased alive on <u>July 16, 1958</u> , and that death occurred at <u>12:48 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>B. T. D. B. O. S. T., M.D.</u>		DATE SIGNED <u>7-16-58</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARTFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>HAURE de GRACE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully administrator</u>			24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

2071261XV0

CERTIFICATE OF DEATH

Reg. Dist. No.

8015

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace DOA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 11 3V01-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>3723 Elm Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Shea</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/29/1948</u>	
9. AGE (In years lost birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM C. SHEA</u>				14. MOTHER'S MAIDEN NAME <u>EVA R. ANDREWS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>WM. C. SHEA-3723 ELM AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN 14</u> , 1953, to <u>JULY 14</u> , 1958, that I last saw the deceased alive on <u>JULY 9</u> , 1958, and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Randolph H. Spitzberg MD</u>				ADDRESS (Street, city or town, state) <u>5329 Reisterstown Rd, Baltimore 15, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RANDOLPH H. SPITZBERG MD</u>				DATE SIGNED <u>7-14-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>POPLAR SPRINGS</u>		22d. LOCATION (City, town, or county) (State) <u>HOWARD CO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>				ADDRESS <u>3818 Roland Ave</u>		24a. RECEIVED BY REGISTRAR <u>—</u>	
				DATE <u>JUL 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES O. WATKINS		M		65		JAN 15 1880		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		JAN 25 1945		BALTIMORE		BALTIMORE		MD	
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
DR. J. H. WATKINS		BALTIMORE HOSPITAL		DR. J. H. WATKINS		JAN 25 1945		JAN 25 1945		J. H. WATKINS		J. H. WATKINS		J. H. WATKINS	
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
DR. J. H. WATKINS		BALTIMORE HOSPITAL		DR. J. H. WATKINS		JAN 25 1945		JAN 25 1945		J. H. WATKINS		J. H. WATKINS		J. H. WATKINS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8016

CERTIFICATE OF DEATH

08029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>10 George Rutenacht.</u>	
3. NAME OF DECEASED (Type or print) First <u>Wale</u> Middle <u>Hamil</u> Last <u>Smith.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Smith.</u>		14. MOTHER'S MAIDEN NAME <u>Tannie Smith (De Moss)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Margaret S. Carrico</u>	
17. INFORMANT <u>Margaret S. Carrico</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> 443X DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic and Hypertensive Cardiovascular Disease</u> DUE TO <u>(?)</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Hemorrhage - right hemiplegia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>10</u> Year <u>1958</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 9th., 1958</u> to <u>July 10th., 1958</u> that I last saw the deceased alive on <u>July 10th., 1958</u> and that death occurred at <u>10:15 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>211 N. Union Ave., July 10th., 1958</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		<u>Harre de Grace, Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer, Benson Md</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 14 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08030

Reg. Dist. No.

8017

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre de Grace</i>			
c. LENGTH OF STAY IN 1b <i>3 days</i>				d. STREET ADDRESS <i>1315 Freedom Street</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>V.</i> Last <i>Walden</i>				4. DATE OF DEATH Month <i>7</i> Day <i>15</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-20-1898</i>	
9. AGE (In years last birthday) <i>59 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Harre de Grace, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>James E. Haycock</i>				14. MOTHER'S MAIDEN NAME <i>Laura Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>214-42-9774</i>		17. INFORMANT <i>Mr. George Walden - Harre de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Hypertensive cardiac vascular disease</i> DUE TO (c) <i>1 week</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma lung</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>7/12/58</i> to <i>7/14/58</i> , that I last saw the deceased alive on <i>7/14/58</i> , 19 <i>58</i> , and that death occurred at <i>8:00 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Dr. H. Walden</i> M.D. <i>407 S. Union Ave</i>				DATE SIGNED <i>7/16/58</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-19-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock - Harre de Grace, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>Alfred Smith</i>	
24b. REGISTRAR'S SIGNATURE				DATE <i>Jul 21 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RAYMOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Age		Sex		Race		Date of Death	
Raymond		25		Male		White		1918	
Place of Birth		Date of Birth		Cause of Death		Manner of Death		Occupation	
New York		1913		Pneumonia		Natural		Student	
Residence at Time of Death		Date of Death		Time of Death		Place of Death		Signature of Physician	
New York		1918		10:00 AM		Home		J. Smith	
Signature of Informant		Date of Report		Signature of Registrar		Date of Registration		Signature of Coroner	
J. Smith		1918		J. Smith		1918		J. Smith	